- all other obstetric care (as defined by the Department) receives a 26.5% increase over the base rate.

Pediatric care (as defined by the Department), except for the technical component provided by an outpatient hospital facility, receives a 15% increase over the base rate.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

Oral language interpreter services, provided by enrolled providers (except inpatient hospitals) to persons with limited English proficiency, are paid the lesser of charges or $12.50 per 15-minute unit of service.

Legislation governing maximum payment rates sets the calendar year at 1989, except that: (1) the calendar year for item 7, home health services, is set at 1982; and (2) the calendar year for outpatient mental health services is set at 1999 (payment is 75.6% of the 50th percentile of calendar year 1999 charges). Rates for services provided by community and public health clinics are increased by 20%, except for laboratory services.

Rate Decrease Effective July 1, 2002: Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2002, before third party liability and spenddown, is decreased by .5 percent from current rates.

Rate Decrease Effective March 1, 2003: Total payment paid to hospitals for outpatient hospital facility services provided on or after March 1, 2003 and through June 30, 2003, before third party liability and spenddown, is decreased by 5 percent from current rates.

Rate Decrease Effective July 1, 2003: Total payment paid to hospitals for outpatient hospital facility services provided on or after July 1, 2003, before third party liability and spenddown, is decreased by 5 percent from the rates in effect on February 28, 2003. This decrease does not include services provided by IHS or 638 facilities.

Exceptions to the 50th percentile of the submitted charges occur in the following situations:

(1) There were less than 5 billings in the calendar year specified in legislation governing maximum payment rates;
(2) The service was not available in the calendar year specified in legislation governing maximum payment rates;
(3) The payment amount is the result of a provider appeal;
(4) The procedure code description has changed since the calendar year specified in the legislation governing

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

(5) The 50th percentile reflects a payment which is inequitable when compared with payment rates for procedures or services which are substantially similar or when compared with payment rates for procedure codes or different levels of complexity in the same or substantially similar category; or
(6) The procedure code is for an unlisted service.

In these instances, the following methodology is used to reconstruct a rate comparable to the 50th percentile of charges submitted in the calendar year specified in legislation governing maximum payment rates:

(1) Refer to information which exists for the first four billings in the calendar year specified in legislation governing maximum payment rates; and/or
(2) Refer to surrounding and/or comparable procedure codes; and/or
(3) Refer to the 50th percentile of years subsequent to the calendar year specified in legislation governing maximum payment rates; and "backdown" the amount by applying an appropriate CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI; and/or
(4) Refer to relative value indexes; and/or
(5) Refer to payment information from other third parties, such as Medicare; and/or
(6) Refer to a previous rate and add the aggregate increase to the previous rate; and/or
(7) Refer to the submitted charge and "backdown" the charge by the CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI.

If a procedure was authorized and approved prior to a reference file rate change, the approved authorized payment rate may be paid rather than the new reference file allowable.

HCPCS MODIFIERS

Medical Assistance pays more than the reference file allowable in the following areas:

20 microsurgery = 35% additional reimbursement.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

22 unusual procedural services = additional reimbursement based on line description or claim attachment. This modifier specifies a ratio for twin delivery and VBAC delivery. All other services are priced according to the service rendered.

99 multiple modifier = may be an increase or a decrease to the reference file allowable depending on the modifiers represented within the 99.

In accordance with Minnesota Statutes, §256B.37, subdivision 5a:

No Medical Assistance payment will be made when either covered charges are paid in full by a third party payer or the provider has an agreement with a third party payer to accept payment for less than charges as payment in full.

Payment for patients that are simultaneously covered by Medical Assistance and a liable third party other than Medicare will be made as the lesser of the following:

(1) the patient liability according to the provider/third party payer (insurer) agreement;

(2) covered charges minus the third party payment amount; or

(3) the Medical Assistance rate minus the third party payment amount.

IHS/638 FACILITIES:

An encounter for a 638 or IHS facility means a face-to-face encounter/visit between a recipient eligible for Medical Assistance and any health professional at or through an IHS or 638 service location for the provision of Title XIX covered services in or through an IHS or 638 facility within a 24-hour period ending at midnight. Encounters/visits with more than one health professional and multiple encounters/visits with the same professional,

within the same service category, that take place in the same 24-hour period, constitute a single encounter/visit, except when the recipient after the first encounter/visit suffers an illness or injury requiring additional diagnosis or treatment. Service categories for IHS/638 facilities are: ambulance, chemical dependency,

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

dental, home health, medical, mental health, and pharmacy.

Services included in the outpatient rate include:

- outpatient hospital ambulatory surgical services
- outpatient physician services
- outpatient dental services
- pharmacy services
- home health agency/visiting nurse services
- outpatient chemical dependency services
- transportation services if the recipient is not admitted to an inpatient hospital within 24 hours of the ambulance trip

Services included in the inpatient rate include:

- inpatient hospital services
- transportation services if the recipient is admitted to an inpatient hospital within 24 hours of the ambulance trip

Inpatient physician services are paid in accordance with the methodology described in item 5.a., Physicians' services.

The ambulatory surgical center facility fee is paid in accordance with the methodology for the technical component of the surgical procedure described in item 2.a., Outpatient hospital services.

24.a. Transportation.

Through December 31, 2000, payment for **life support transportation** is the lower of:

(1) submitted charge; or
(2) 50th percentile of Medicare prevailing charge for 1982, plus a 10.725% increase over the base rate.

Effective July 1, 1999 this rate is increased 5%.

Effective January 1, 2001, payment is the lower of:

(1) submitted charge; or
(2) the Medicare unadjusted base rate.

Effective July 1, 2001, payment is the greater of:

(1) the payment rate in effect on July 1, 2000; or
(2) the Medicare payment rate.

- A0427 $430.03
- A0429 $430.03
- A0435 $6.49

If the provider transports two or more persons simultaneously in one vehicle, the payment is prorated according to the schedule for special transportation services, below. Payment for ancillary services provided to a recipient during life support transportation must be based on the type of ancillary service and is not subject to proration.

Payment for **special transportation** is the lowest of:

(1) for persons not requiring a wheelchair-accessible van, the submitted charge or the medical assistance maximum allowable charge, which is a base rate of $12.00 and ~~$1.40~~ $1.35 per mile ~~or~~;

(2) for persons requiring a wheelchair-accessible van, the submitted charge or the medical assistance maximum allowable charge, which is a base rate of $18.00 and $1.40 per mile; or

maximum payment rates, therefore, the prevailing charge information reflects the same code but a different procedure description;

24.a. Transportation. (continued)

(3) for persons requiring a stretcher-accessible vehicle, the submitted charge or the medical assistance maximum allowable charge, which is a base rate of $36.00 and $1.40 per mile, plus an attendant rate of $9.00 per trip.

If the provider transports two or more persons simultaneously in one vehicle from the same point of origin, the payment must be prorated according to the following schedule:

NUMBER OF RIDERS	PERCENT OF ALLOWED BASE RATE PER PERSON IN VEHICLE	PERCENT OF ALLOWED MILEAGE RATE
1	100	100
2	80	50
3	70	34
4	60	25
5-9	50	20
10 or more	40	10

Payment for **air ambulance transportation** is consistent with the level of medically necessary services provided during the recipient's transportation.

Through December 31, 2000, payment is the lower of:

(1) submitted charge; or
(2) the 50th percentile of Medicare's prevailing charge for 1982, plus a 10.725% increase over the base rate.

Effective July 1, 1999 this rate is increased 5%. Effective January 1, 2001, payment is the lower of:

(1) submitted charge; or
(2) the Medicare unadjusted base rate.

Payment for air ambulance transportation of a recipient not having a life threatening condition is at the level of medically necessary services which would have been otherwise provided to the recipient at rates specified for other transportation services, above.

24.a. Transportation. (continued)

Payment for **special transportation for a child receiving EPSDT rehabilitative or personal care services identified on an IFSP or IEP** under the Individuals with Disabilities Education Act (IDEA) and provided by a school district during the day is determined by multiplying the number of miles the child is transported to or from a provider of rehabilitative services by the per mile rate of $2.21.